Oakland Physical Therapy, P.C.
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PATIENT HISTORY QUESTIONNAIRE

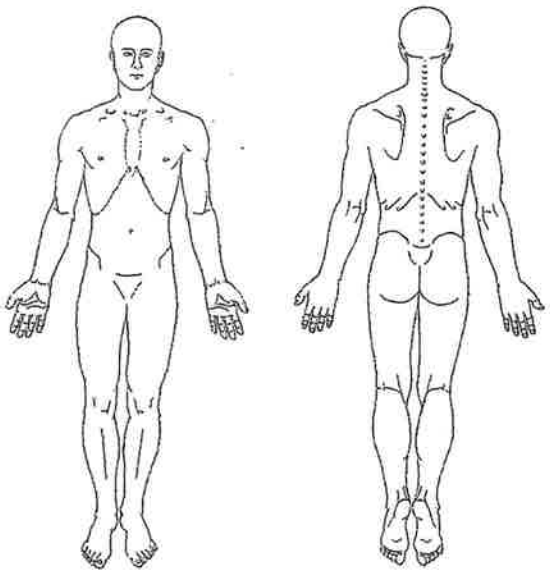
Name: _____
D.O.B.: _____
Diagnosis: _____

Date: _____

Have you had physical therapy this year? _____

Occupation_____ Age_____ Height_____ Weight_____

1. Where is your pain located? _____
   (Please mark the areas of pain on the diagram to the right)



2. When did your pain begin? _____
3. Is your pain the result of an injury? YES NO

   If YES, please explain _____

   _____
4. Have you ever had anything similar before? YES NO
   If YES, please explain_____

   _____
5. Circle all words that describe your pain:

   Constant Intermittent Sharp Dull

   Burning Radiating Throbbing Cramping Other
6. What makes your pain worse? _____
7. What eases your pain? _____
8. Can you sleep through the night? YES NO
9. How do you feel in the morning? STIFF SORE FINE
10. Do you feel better or worse at the end of the day? _____
11. Does it hurt to cough, sneeze, or take a deep breath? YES NO
12. Please place a check mark next to any special test you have had:

Special Test	Date of Test
_____ X-rays	_____
_____ Cat Scan	_____
_____ MRI	_____
_____ EMG	_____
_____ Other _____	_____

13. At the present time, are you getting: BETTER WORSE STAYING THE SAME
14. What were you able to do before that you are not able to do now? _____

_____

1. Do you have a history of:

Shortness of breath	YES	NO
Allergies	YES	NO
Asthma	YES	NO
Bronchitis	YES	NO
Kidney disease/stones	YES	NO
Polio	YES	NO
Emphysema	YES	NO
Anemia	YES	NO
Rheumatic fever	YES	NO
Ulcers	YES	NO
Tuberculosis	YES	NO
Intestinal disorder	YES	NO
Circulatory problems	YES	NO
Liver/gallbladder disease	YES	NO
Bursitis	YES	NO
Hip disease	YES	NO
Hernia	YES	NO
Gout	YES	NO
Paralysis	YES	NO
Epilepsy	YES	NO
Serious injury	YES	NO

2. Have you had or do you experience:

Nausea/vomiting	YES	NO
Fever/chills/sweats	YES	NO
Unexplained weight change	YES	NO
Numbness or tingling	YES	NO
Muscular weakness	YES	NO
Fainting spells	YES	NO
Dizziness	YES	NO
Night pain	YES	NO
Bowel or bladder changes	YES	NO
Headaches	YES	NO
Surgery	YES	NO
Difficulty swallowing	YES	NO
Frequent leg cramps	YES	NO
Jaw pain	YES	NO

3. Have you (or an immediate family member) ever been told you have:

Cancer	MYSELF	FAMILY MEMBER
High Blood Pressure	MYSELF	FAMILY MEMBER
Diabetes	MYSELF	FAMILY MEMBER
Heart disease	MYSELF	FAMILY MEMBER
Angina/chest pain	MYSELF	FAMILY MEMBER
Stroke	MYSELF	FAMILY MEMBER
Arthritis	MYSELF	FAMILY MEMBER

4. Have you had a recent illness (upper respiratory infection, flu, urinary tract infection, etc.)? YES NO

   If yes, please explain _____

5. Please list all medications you are taking: _____

   _____

6. How often do you feel stress is a significant factor in your life? Never Seldom Occasionally Regularly Always

7. Date of last complete physical examination: Month _____ Year _____

8. Do you smoke? YES NO If YES, packs per day? _____ For how long? _____

9. If female, are you menstruating regularly? YES NO

   OPTIONAL:

10. Do you use alcohol? YES NO If YES, drinks per day? _____ per week? _____